Surency Life & Health Insurance Company
Surency Vision Member Certificate

This Booklet is issued under the terms of your Group Vision Plan.

Your Group has contracted with Surency Life & Health Insurance Company to provide the Benefits described in this Booklet. This Booklet summarizes your vision care benefits and how you may maximize them. This Booklet constitutes a summary only. The Group Vision Plan is governed by the terms of the Group Contract between your Group and Surency. Those terms govern if information in this Booklet is not the same.

If a word or phrase starts with a capital letter, it has a special meaning in this Booklet. It is defined in the Definition Section, where used in the text, or it is a title. There are key words you will see repeated throughout this Booklet. We've highlighted them here to make the Booklet easier to understand.

We, us, our, and **Surency** refers to Surency Life & Health Insurance Company.

You, your, and **Covered Person** refers to you and your enrolled Dependents.

Save this Booklet in a convenient place and refer to it whenever you have questions about your vision care coverage.

Contact us.
Member Services.
316.462.3316 or toll free 866.818.8805

Visit us online at:
http://www.surency.com/vision

You can search for a Provider, download a claim form, or access other personal account information.

THIS IS A LIMITED POLICY–READ IT CAREFULLY.
The Schedule of Benefits provides only a brief outline of some of the important features of your policy. The Schedule of Benefits is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company.
IT IS IMPORTANT THAT YOU READ YOUR BOOKLET.

Schedule of Benefits

This Schedule of Benefits should be read in conjunction with your Booklet. Your Booklet will provide you with additional information about your Prescription Eyewear Benefits, including information about your Plan's Limitations and Exclusions. If you seek services and materials from a Non Network Provider, you may have more Out Of Pocket Costs.

Prescription Eyewear Benefits
Group # 40700-000-00000-00000
Custom Insight – A

SURENCY BENEFITS - BASIC PLAN		
Service or Item	**Network**	**Non Network**
Eye Exams: Subject to $50 Copayment		
Eye Exam, M.D. or O.D.	Covered in Full After Copayment	Up to $38*
Eyeglasses: Subject to $25 Materials Copayment		
Frame	Up to $100 retail*	Up to $45*
Single Vision Lenses, pair	Covered in Full After Copayment	Up to $31*
Bifocal Lenses, pair	Covered in Full After Copayment	Up to $51*
Trifocal Lenses, pair	Covered in Full After Copayment	Up to $64*
Lenticular Lenses, pair	Covered in Full After Copayment	Up to $80*
Progressive Lenses, pair	Not Covered	Not Covered
High Index Lenses, pair	Not Covered	Not Covered
Polycarbonate Lenses, pair	Member pays up to $40	Not Covered
Scratch Coat	Member pays up to $15	Not Covered
UV Coat	Member pays up to $15	Not Covered
Contact Lenses: Not Subject to Materials Copayment		
Elective/Cosmetic Retail	Covered up to $150 retail*	Covered up to $105*
When Medically Necessary	Covered in Full	Covered up to $105*
Contact Lens Exam Fitting Fee: $35 Copayment		
Standard Contacts**	Covered in Full after Copayment	Not Covered
Specialty Contacts***	10% off Retail Price, minus $55 allowance	Not Covered
Frequencies		
Eye Exam	Covered once every calendar year.	
Frames	Covered once every calendar year.	

Frame Lenses	Covered once every calendar year unless contact lenses has been elected.
Contact Lenses	Covered once every calendar year unless frame lenses has been elected.

* You are responsible for any charges above the allowance.

** Standard contact lens fit and up to two follow up visits covered once a comprehensive eye exam has been completed. Typical standard lens wearers include disposable, daily wear or extended wear lenses.

*** Specialty contact lens fit and up to two follow up visits covered once a comprehensive eye exam has been completed. Typical specialty lens wearers include toric, gas permeable and multi-focal lenses.

Medically necessary contact lenses:

- All requests for medically necessary contact lenses must be submitted by your Surency Insight Network provider for review and approval by our Medical Director before a claim will be processed for the service.
- Reimbursement for one pair of these lenses per plan year will be considered as payment in full.

Service frequencies are determined by calendar year, not date of service.

Vision Benefit Allowances are available once per plan year toward the cost of vision services and materials covered under the Plan. Any unused allowance balance remaining may not be applied to any other services.

Please note: Not all Walmart Vision Centers are NETWORK providers, however you will still receive NETWORK benefit reimbursements. Members utilizing Non Network Walmart will need to complete and file their own paper claim for reimbursement. To obtain the Surency Claim Form you may call customer service at (866) 818-8805 or visit the Surency website www.surency.com/stateofkansas. Further information can be found on page 11 **If using a Non Network Provider** and Page 16 **Claim Submission** for timelines on reimbursements.

Table of Contents

Schedule of Benefits. 2
How your Plan works 6
Choosing a Provider or Retailer 6
Network Provider 6
Participating Retailer 6
Non Network Provider 6
What your Plan covers 7
What additional Benefits are offered under your Plan 7
What value-added features apply to your Plan 8
Combination of Benefits and Savings 8
Eye Glasses Savings 8
Contact Lenses Savings 8
Laser Vision Correction Savings 8
What is limited or not covered under your Plan 8
What is limited under your Plan 9
What your Plan does not cover 9
How to use your Plan (Claims and Payments) 11
How we pay your Claims 11
How to file a Claim 11
Deadline for filing Claims 12
How your Claim is processed 12
How to appeal a Claim 12
How we handle your appeal 13
Coordination of Benefits 14
Determine Primary and Secondary Plan 14
Coverage 14
Recovery of Overpayment 15
Eligibility, Enrollment, Changes, and Termination 15
Who is an Eligible Person 15
Who is an eligible Dependent 15
Applying for Coverage 16
Initial and Annual Open Enrollment Periods 16
Special Enrollment Periods. 16

Eligibility Changes 16
COBRA Continuation Coverage 16
Eligibility for COBRA 16
Election of COBRA 17
When your coverage ends under this Plan 17
Important information about your Plan 18
Changes in the Plan 18
Notices 18
Legal Action 18
Definitions 18

How your Plan works

Your Plan covers eligible vision care services and materials from Providers and Participating Retailers. Your level of Benefits will vary based on where you receive vision care services. Reviewing this Booklet will show you how to access and maximize your vision care benefits.

It is important that you carry your Surency Vision ID card at all times and present it when you visit any Provider or Participating Retailer. Your Surency Vision ID card identifies you as a person covered by Surency Vision. When you show your Surency Vision ID card to your Provider or Participating Retailer, they will file your claims for you in most cases.

Choosing a Provider or Retailer

Your Plan allows you to choose where you receive vision care services and materials. You may choose a Network Provider, Participating Retailer, or a Non Network Provider. Your level of Benefits will vary based on which Provider or Participating Retailer you choose.

Network Provider

If you choose to receive vision care services from one of the Network Providers, most Benefits as described in the Schedule will be covered at no or low cost after any applicable Copays. The Network Provider will file your Claims for you. We will pay the Network Provider. If you choose a Network Provider, you will maximize your savings on vision care through your Plan.

Many Network Providers offer complete vision care services, but some may offer partial services only. You may review the Provider listing at our website or call our Member Services to see what services each Provider offers.

Participating Retailer

There are some Participating Retailers who have agreed to bill Surency for some Benefits, such as dispensing eye glasses or contact lenses. You may review the Participating Retailer listing at our website or call our Member Services to find the Participating Retailers near you.

Non Network Provider

If you choose to go to a Provider who does not participate in Surency's Network, your vision care will be covered at a lower level of Benefits. You are responsible for paying your Provider the full fee. We may reimburse you up to the Reimbursement amounts listed in the Schedule. We will pay you after we have received an itemized bill and all information necessary to process the claims.

What your Plan covers

The Schedule of Benefits describes the Benefits available to you from Network Providers, Non Network Providers, and Participating Retailers. You will receive the highest level of Benefits by using a Network Provider. Examples of how the Schedule applies to your vision care coverage:

1. **Network Provider**

   If you choose to visit a Network Provider to obtain prescription eye glasses, you would present your Surency Vision ID card at the visit. You pay your $50 Copay at the time of the Exam. You pay a $25 Copay when you order your frame and Single Vision Lenses through your Provider. Surency pays your Provider up to your $100 Allowance for the frame. You receive a 20% discount on the remaining balance for your frame.

2. **Participating Retailer**

   If you choose to visit a Participating Retailer, you would present your Surency Vision ID card at the visit. You pay a $25 Copay when you order your frame and Single Vision Lenses through the Participating Retailer. Surency pays your Participating Retailer up to your $100 Allowance for the frame. You receive a 20% discount on the remaining balance for your frame.

3. **Non Network Provider**

   If you choose to visit a Non Network Provider to obtain prescription eye glasses, you would present your Surency Vision ID Card at the visit. You pay the Provider in full for all services at the time of the visit. You ask your Provider for the itemized bill showing the amounts for each service. You follow the claim filing instructions in this Booklet. Surency reimburses you up to $38 for your Exam, $31 for Single Vision Lenses, and $45 for the frame.

What additional Benefits are offered under your Plan

Your Plan covers additional Benefits other than these listed in the Schedule. These additional Benefits are available through a Network Provider only unless the additional Benefits subsection specifies otherwise. The Group Contract describes your actual coverage. Your additional Benefits may be subject to the Limitations and Exclusions under the Group Contract.

1. **Retinal Screening**. No more than a $39 Copay on routine retinal screening as an add-on to your Exam. Retinal imaging takes a digital picture of the back of your eye. This helps your Provider find diseases and check the health of your eyes.

What value-added features apply to your Plan

You may receive additional discounts and savings through your Plan. Please note that not all Providers or retailers offer or accept these discounts and savings. Please check with your Provider or retailer about discounts and savings before receiving services or purchasing materials. These discounts do not apply to Network Providers' vision care services or contact lenses. These value-added features are not insured benefits.

Combination of Benefits and Savings

You cannot combine your Plan's discounts with any other discounts or promotions. Retail prices may vary by location. Your Plan may not cover services or materials covered by any other plan providing vision care.

Eye Glasses Savings

You receive 40% off of complete pairs of eye glasses purchases once your Plan's funded Benefit has been used. Those discounts are available through Network Providers only.

Contact Lenses Savings

You receive 15% off of Conventional Contact Lenses once your Plan's funded Benefit has been used. Those discounts are available through Network Providers only.

You may order replacement contact lenses online after your first purchase to save more. Your Contact Lenses Allowance does not apply to this service. For more details, visit www.surency.com/vision.

Laser Vision Correction Savings

You receive 15% off of the retail prices or 5% off of the promotional prices for LASIK or PRK through the U.S. Laser Network. This gives you easy access to their Providers who specialize in laser vision correction. These discounts may not be available from a Provider near you since only specialized Providers may perform these elective procedures. Finding a specialized Provider near you is easy. Simply call the U.S. Laser Network at 1.877.552.7376 for these Providers' locations and available discounts.

What is limited or not covered under your Plan

Your Plan covers visual needs, but does not cover cosmetic materials. The Limitations and Exclusions of Benefits listed below apply to Network Providers, Participating Retailers, and Non Network Providers.

What is limited under your Plan

Your Benefits may be limited as listed below unless the Group Contract and Schedule specifies otherwise.

1. Allowances are available once during a Plan Year toward the cost of each Benefit. If you have any Allowance remaining after using a Benefit, the remaining Allowance amount cannot be applied to any other Benefit in the same Plan Year.
2. Some Benefits may be limited by age and frequency. These limits are specified in the Schedule. Benefits are not available more frequently than specified in the Group Contract and Schedule, even if those services or materials are Medically Necessary.
3. We cover Medically Necessary Contact Lenses only if you are diagnosed with one of the conditions listed below. All requests for Medically Necessary Contact Lenses must be submitted by the Network Provider for review and approved by us before a Claim will be processed for the service.
    a. *Anisometropia* if eye wear prescription has a 3D difference in meridian powers.
    b. *High Ametropia* if eye wear prescription exceeds -10D or +10D in meridian powers in either eye.
    c. *Keratoconus* if Best-Corrected Visual Acuity through eye wear prescription is worse than 20/30 in either eye.
    d. Vision Improvement when *Keratoconus* is not present, if vision can be corrected by 2 lines on the visual acuity chart.

What your Plan does not cover

Your Plan does not cover the services and materials listed below unless the Group Contract and Schedule specifies otherwise.

1. Aniseikonic Lenses.
2. Any frame that the manufacturer has imposed a no discount policy on.
3. Replacement of broken, lost, or stolen lenses and frames supplied under your Plan. We will replace those lenses and frames at normal intervals when those services are available as shown in the Schedule.
4. Two pairs of glasses in lieu of bifocals.
5. Any additional services required for contact lenses other than Exam and Contact Lens Fit and Follow-up.
6. Benefits combined with any discount, promotional offering, or other group benefit plans.
7. Services that are not consistent with widely accepted and established standards of vision care or are considered unnecessary procedures by Surency.
8. Charges for any consultation other than what the Group Contract provides for.

9. Services and materials more than those covered under your Plan needed due to a job requirement.
10. Non-prescription protective eye wear.
11. Services for vision training, orthoptics, and subnormal visual aids.
12. Any non-prescription lenses, eye or sun glasses, or contacts. Plano Lenses that have no refractive power.
13. Services and materials not covered under the Group Contract.
14. Medical, pathological, or surgical treatment of the eyes if not a covered Benefit.
15. Benefits that are not completed or delivered.
16. Services and materials rendered by any person or entity that is not a Provider or Participating Retailer.
17. Services or materials covered by any other group benefit plan. This Plan's discounts are not applied towards benefits covered by any other group benefit plan
18. Charges for completion of forms.
19. Services or materials, including, but not limited to, emergency treatment covered by any other medical plans.
20. Benefits obtained outside of the United States.

No Benefits will be paid if the services and materials are:

1. Received before your coverage begins.
2. Received after your coverage ends. Unless you:
    a. Ordered materials before coverage ended and received those materials no later than 30 days after the order date.
    b. Started service before coverage ended and that service is completed no later than 30 days after the service start date.
3. Covered under federal, state, or local laws and regulations. This exclusion applies whether or not you waive your rights under these laws and regulations or any other settlements. It does not apply to laws that make the government programs the secondary payor after Benefits have been paid. Benefits will not be provided for vision care services or injuries or diseases related to your job to the extent you are covered or are required to be covered by Workers' Compensation laws. If you enter into a settlement giving up your right to recover future vision care benefits under a Workers' Compensation law, the Group Contract will not pay those vision care benefits that would be payable in absence of that settlement.
4. Covered under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.
5. For your illness or injuries caused by:
    a. War, declared or undeclared.
    b. Participating in a riot or civil disorder.

c. Committing or attempting to commit a crime.
d. Intentional self-inflicted harm.

6. For accidental injuries arising from motor vehicle accidents if the Benefits are payable under any medical expense payment provision of any motor vehicle insurance policy, including Benefits mandated by law.
7. Charges for vision care services that no charge is normally made, or no charge would be made but for the Group Contract, are not Benefits.

How to use your Plan (Claims and Payments)

How we pay your Claims

If you go to a Network Provider or Participating Retailer, they will file your Claims for you. We will pay them for any Allowances. You are responsible for any Copays at the time of the visit and remaining balances.

If you use a Non Network Provider, you may have to file your Claims yourself. You should file your Claims as soon as you can. We will pay you immediately after we receive all the information we need to process your Claim. We may reimburse you up to the Reimbursement amounts as listed in the Schedule. These Reimbursement amounts shown are the maximums for each Plan Year. The reimbursement you may receive is the lesser of the Reimbursement amount shown in the Schedule and the amount charged.

In all cases, our payment relieves Surency of any further liability for the services and materials.

How to file a Claim

To file a Claim, follow these 4 steps:

1. Pay the Provider the full amount of the bill. Request a copy of the itemized bill that shows the amounts for each service.
2. To obtain a copy of the "Out of Network Claim Form":
   - Call 316.462.3316 in Wichita or 866.818.8805.
   - Visit our mobile app.
   - Visit our website at www.surency.com/vision/forms.
3. Complete and sign the claim form. Make sure you include copies of any itemized bills for covered services. Each itemized bill must contain the following:
   - Name and address of the Provider.
   - Name of patient.
   - Date of service.
   - Each service received and the amount paid.

4. Mail copies of the completed claim form and itemized bills to:

   Surency Vision
   Attn: OON Claims
   PO Box 8504
   Mason, OH 45040- 7111

Deadline for filing Claims

You should submit your Claims no later than 90 days after the completion of services. Surency will not pay any Claims that are submitted more than 12 months after the completion of services.

How your Claim is processed

We process your Claims based on established guidelines and criteria to ensure your Plan's coverage determinations are applied consistently. Your filed Claims are processed within the time permitted by state law, but generally no longer than 30 days after receipt. We may extend this period for an additional 15 days if needed for matters beyond our control, including cases where a Claim is incomplete. If we need an extension, we will notify you before the end of the initial 30-day period.

Your Plan may deny a Claim if you do not provide the information we need to process the Claim. The claim denial will let you know what additional information we need to finish processing the Claim. You or your Provider must submit the additional information to us no later than 1 year after the date of service or 45 days from the date we notified you that we needed additional information, whichever is later. Once your Plan processes your Claim, we will send you an Explanation of Benefit immediately.

If your claim is denied, you will receive an Adverse Benefit Determination. The Adverse Benefit Determination will include:

1. The reason(s) for the denial.
2. The Plan provision(s) that the denial is based on.
3. A description of any additional material or information we need to reopen the Claim for consideration and an explanation of why that material or information is needed.
4. A description of your Plan's appeal procedures and time limits.

If all or part of a Claim was not covered, you have the right to see, upon request and at no charge, any rule, guideline, or criterion that your Plan relied upon in making the coverage decision.

How to appeal a Claim

If your Claim is denied, in whole or in part, you or your Authorized Representative may request a review of the Adverse Benefit Determination. The request for review should be in writing and received by us no later than 180 days after your notice of

the denial. If you do not receive an Explanation of Benefits 30 days after submitting your Claim, you may request a review no later than 180 days after that initial 30-day period.

On the other hand, if you have any questions, comments, or information about any Claim, you may call our Member Services at 316.462.3316 in Wichita or 866.818.8805.

When you submit a written request for review, please include a copy of the Explanation of Benefits if you have a copy and the information listed below.

1. Group number and Surency Vision ID number.
2. Covered Person's name and date of birth. If the Covered Person is not a Member, the Member's name and date of birth must be included.
3. Name of the Provider who provided the service.
4. Date of service.
5. Description of the service provided.
6. The charged amount.
7. Claim number.

You may state the reasons you believe that the claim denial was in error. You may submit any statements, documents, or written arguments in support of the Claim.

You or your Authorized Representative should mail all requests for appeals to:

Surency Vision
Attn: Member Services
P.O. Box 789773
Wichita, KS 67278

How we handle your appeal

We will review your appeal and all information you submit. We will conduct a new review of the Claim with no deference to the initial coverage decision. The person reviewing your appeal will not be the same person who decided the initial claim denial, and will not be that person's subordinate. Appeals involving Medical Necessity will be reviewed by a licensed vision care professional. We will give you the opportunity to review relevant documents, submit any statements, documents, or written arguments in support of the Claim.

We will acknowledge receipt of your appeal promptly and will resolve and respond to it within 60 days for Claims after the date of service.

If the initial coverage decision is upheld, we will provide you a notice listing the reason(s) and the Plan provision(s) that the decision is based on. You will be entitled to request and receive, at no charge, the following:

- Reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;

- Any rule, guideline, or criterion relied upon in the coverage decision(s);
- The explanation of the scientific or clinical judgement as it relates to the patient's medical condition if the coverage decision was based on the Medical Necessity or experimental nature of the care; and
- The identity of the experts who consulted with the Plan regarding the appeal.

Coordination of Benefits

IMPORTANT NOTICE – This is a summary of only a few of the provision of your Plan to help you understand the Coordination of Benefit rules. This is not a complete description of all of the coordination rules and procedures. This summary does not change or replace the language contained in the Group Contract which determines your benefits.

It is common for family members to be covered by more than one health care plan. This happens, for example, when two spouses both work and choose to have family coverage through both employers.

If your vision care is covered by more than one plan, you may:

Use each plan by itself (based on what each plan offers) for either two separate exams or materials from each plan. For example, contact lenses from one plan and eye glasses from the other plan or two sets of glasses (one pair from each plan).

Or

Choose to have both plans pay for one set of services to offset plan Copays, Lens Add-Ons, and frame coverage, up to, but not more than the billed amount. For more details on the Coordination of Benefits, ask your Provider.

Determine Primary and Secondary Plan

- The plan that covers you as an Employee is primary.
- The plan that covers you as a Dependent is secondary.
- If the patient is a Dependent Child and is covered under both parents' plans, the parent whose date of birth falls first in the Calendar Year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Coverage

The primary plan pays as if the secondary plan does not exist. If your plan is the secondary plan, you may receive Allowances that will be used to pay up to, but not more than, your Out Of Pocket Costs.

Recovery of Overpayment

We may recover any overpayment of Benefits from any persons or organizations listed that we have determined to have benefited from the overpayment.

- Any person to, or for whom those payments were made.
- Any insurance company.
- A facility or provider; or
- Any other organization.

The payment amounts may include the reasonable cash value of any Benefit.

Providers and you have the responsibility to return any overpayments to us. You may be required to cooperate with us to secure Surency's right to recover any excess payments made on your behalf, or on behalf of other Covered Person(s) enrolled under your family coverage.

We have the responsibility to make additional payments if we made any underpayments of Benefits.

Eligibility, Enrollment, Changes, and Termination

Who is an Eligible Person

Unless otherwise specified in the Group Contract, the Benefits described in this Booklet will be given to persons who:

- Meet the definition of an Eligible Person as specified by the Group Contract.
- Have applied for this coverage and received an eligibility determination from the Group and the Plan.

The date you become eligible is the date you satisfy the eligibility provision specified by your Group. Check with your Group Administrator for eligibility requirements that apply to your coverage.

Who is an eligible Dependent

An eligible Dependent is defined as:

- Your Spouse.
- Your Dependent Child.
    - Your Plan may request proof of a Dependent Child's age, dependency, or disability status upon Enrollment on one or more occasions.
    - We cover your newborn Dependent Child from birth date for the first 31 days. You must pay the required premiums for your newborn Dependent Child within 31 days after the birth date to continue your newborn Dependent Child's coverage beyond that 31-day period.
    - We cover your disabled Dependent Child beyond the limiting age if you submit satisfactory proof of that Dependent Child's disability status.

- If you and your Spouse are both employed by the Group, one of you may enroll as a Member and the other as a Dependent, or both of you may enroll as Members. You may cover your Child (ren) under your coverage or your Spouse's coverage, but not both.
- Dependents may be enrolled under one Member only.

Applying for Coverage

You may apply for coverage in this Plan for yourself or your Dependent or both of you.

You may enroll in or change plans for yourself or your Dependent or both of you during one of the following enrollment periods.

Initial and Annual Open Enrollment Periods

Your Group will designate initial and annual open enrollment periods during which you may apply for or change coverage in a plan for yourself or your Dependent or both of you. Your and your Dependents' Effective Dates will be assigned by the Plan under the terms of the Group Contract. Your Group is responsible for determining your waiting period. If you have questions about your waiting period, contact your Group Administrator.

Special Enrollment Periods

Your Plan includes special enrollment periods during which you may enroll in or change coverage in the Plan for yourself or your Dependent or both of you who declined coverage in the past. You must apply for coverage no later than 30 days after any Qualifying Life Event.

Coverage under special enrollment will be effective no later than the first day after the Plan receives your application for enrollment for yourself or your Dependent or both of you.

Eligibility Changes

It is your responsibility to notify the Plan of any change to a Covered Person's name or address. You may call Member Services at the number shown on your Surency Vision ID card or visit our web site at http://www.surency.com/vision.

Any change will be effective at the end of the month during which eligibility changes, except as otherwise provided in the Group Contract.

COBRA Continuation Coverage

Covered Persons may be eligible to continue coverage under COBRA. Check with your Group Administrator to determine if your Group is subject to COBRA.

Eligibility for COBRA

Qualifying Life Events means events that cause a Covered Person to lose coverage under this Group Vision Plan. The type of Qualifying Life Event determines who the

qualified beneficiaries are for that event and the period that the Plan must offer COBRA. When a Qualifying Life Event occurs, eligibility under this Plan may continue for you or your Eligible Dependent or both of you who were covered on the date of the Qualifying Life Event.

You or your Eligible Dependent is responsible for notifying the Group Administrator no later than 60 days after the occurrence of the Qualifying Life Events listed below.

- Your divorce or legal separation.
- Your Dependent Child's loss of Dependent status under the Plan.
- The birth, adoption, or placement for adoption of a Child while you are covered under COBRA.

Election of COBRA

You or your Eligible Dependent or both of you must elect COBRA no later than 60 days after the last to occur of the two listed dates.

- The date the Qualifying Life Event would cause you or your Dependent or both of you to lose coverage.
- The date your Group Administrator notifies you or your Eligible Dependent or both of you of your COBRA rights.

If you have questions about COBRA, ask your Group Administrator.

When your coverage ends under this Plan

In general, the Covered Person's coverage will end when that Covered Person ceases to be eligible or the required premiums are not paid within the 10-day grace period each month in accordance with the Group Contract. Unless otherwise agreed to in writing by Surency, the Covered Person's coverage ends on the last day of the month the last payment was made. The Covered Person's coverage ends on the last day of the month during which eligibility ceases. All Benefits cease when the Covered Person's coverage is terminated.

Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or misrepresentation of fact in applying for or obtaining coverage under the Group Contract. Your coverage will end immediately if you file a false Claim.

If your premiums are not paid, your coverage will stop at the end of the month that your premiums were last paid, except as otherwise provided in the Group Contract.

This Plan will continue until terminated by either your Group or Surency. Termination of the Group Contract ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of that termination. Your coverage will end whether or not that notice is given.

Important information about your Plan

Changes in the Plan

Your Group and Surency may change your Benefits on one or more occasions. Any changes to the Plan will take effect on the date of that change.

Notices

If we change the Plan, we will send you written notice. Any notice required under this Plan must be in writing. Notice given to your Group will be sent to your Group's address. Notice given to a Covered Person will be sent, at our option, to your Group or to your address as it appears on our records. Your Group or a Covered Person may change your address for giving notice.

Legal Action

You may not bring any legal action against Surency no earlier than 60 days after a claim is filed, on the condition that you exhaust the internal administrative appeal rights stated in this Booklet before bringing that legal action. All legal action by any person subject to the Group Contract must be commenced no later than 5 years after the date that Claim first arises. This time limit applies to matters relating to this Plan, to our performance under this Plan, or to any statement made by an employee, officer, or director of Surency regarding this Plan or the Benefits available to a Covered Person.

Definitions

This section defines terms that have special meanings in this Booklet. If a word or phrase starts with a capital letter, it has a special meaning. It is defined in this section or where used in the text or if it is a title.

Adverse Benefit Determination

An Explanation of Benefit issued when a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively based on fraud or misrepresentation.

Allowance

A fixed amount or fixed percentage that may be applied toward the payment for a service or material as specified by the Benefit.

Anti-Reflective Coating

A lens add-on that allows more light to pass through the lens. This type of lens add-on cuts down on glare and distracting reflections.

Authorized Representative

The person entitled to act on behalf of you or any other Covered Person(s) for a Claim or appeal. The Plan must receive a written and notarized notice signed by you or a Covered Person before the Plan will recognize a person as an Authorized Representative.

Benefit

Vision care service or materials listed as covered, subject to the terms of the Group Contract.

Best-Corrected Visual Acuity

Best possible vision you can achieve with corrective lenses.

Bifocal Lenses

Lenses for those who need vision correction for both far away and up close.

Booklet

This document given to you that describes the Benefits covered by the Group Contract. This Booklet contains Copay requirements, coverage details, Limitations and Exclusions, and the responsibilities of both you and Surency.

Calendar Year

The 12-month period starting on January 1 and ending on December 31. This 12-month period may not be the same as the Plan Year. To find out when your Plan begins, you can check your plan documents or ask your Group Administrator.

Child

Natural children, stepchildren, adopted children, children placed for adoption, and children under legal guardianship.

Claim

A request for payment or reimbursement that your Provider or you submit to us when you get vision care you believe are covered.

COBRA

A federal law that may allow you to temporarily keep coverage after your employment ends, you lose coverage as a Dependent of the Member, or another Qualifying Life Event. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay all of the premiums, including the share the employer used to pay, plus a small administrative fee of not more than 2% of premiums.

Conventional Contact Lenses

Contact lenses designed for long term use of up to one year. These contact lenses can be either daily wear or extended wear.

Coordination of Benefits

A way to figure out who pays first when two or more health care or vision care plans are responsible for paying the same vision care claim.

Copay

A flat fee that you must pay for some covered services. Refer to the Schedule of Benefits for any Copays applicable to your coverage.

For example, you visit a Network Provider and need Premium Progressive Vision Lenses. These lenses may cost $200. Your Copay for these lenses is $65. You pay $65 at the time of the visit. Then your Provider will bill us for up to the $120 Allowance. Your remaining balance of $15 is discounted by 20%. You pay $12 when your Provider bills you.

Covered Person(s)

The Member and each of his or her Dependents (if any) covered under this Plan.

Dependent

An Eligible Person other than the Member, such as a Spouse and a Child under the age of 26, as shown in the Eligibility, Enrollment, Changes, and Termination Section.

Disposable Contact Lenses

Contact lenses designed to be thrown away on a regular basis.

Effective Date

The date your coverage begins.

Eligible Person

A person who is entitled to apply to be a Covered Person as specified in the "Eligibility, Enrollment, Changes, and Termination" Section.

Employee

An Eligible Person who is employed by the Group.

Exam

Comprehensive *ophthalmological* service composed of a general, routine evaluation of your eyes and its functions.

EyeMed

EyeMed Vision Care, LLC, First American Administrators, Inc., and their agents.

Group

The person or entity, usually your employer, that contracts with Surency on behalf of you and other employees.

Group Administrator

The person or group of people, identified by your Group, who are responsible for managing your Group Vision Plan.

Group Application

The written request for coverage by your Group to Surency. The Group Application includes all data and related information that Surency may require on one or more occasions.

Group Contract

The contract between your Group and Surency, including, but not limited to, the Group Application and any amendments.

Group Vision Plan (or **Plan**)

This vision care coverage plan offered to you by your Group through Surency Vision.

High Index Lenses

Thinner and lighter lenses for those who have strong prescriptions for nearsightedness, farsightedness, or *astigmatism*.

LASIK

A type of refractive surgery to correct nearsightedness, farsightedness, and *astigmatism*.

Lens Add-On

Optional lens coatings and add-ons that do not come with Plastic (Basic) Lenses. Examples of lens coatings and add-ons are Polycarbonate Lenses, Scratch-Resistant Coating, Tint, and UV Treatment. These add-ons may be referred to as an "option" or "upgrade".

Lenticular Lens

Lenses for those who have Severe Vision Problems that require a high plus power that cannot be achieved with a traditional lens.

Limitations and Exclusions

Situations, conditions, or circumstances that are listed in your Booklet as not covered regardless of Medical Necessity or their approval or prescription by your Provider.

Medically Necessary

Vision care services or materials needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of vision care as determined by Surency.

Medically Necessary Contact Lenses

Contact lenses designed for a person diagnosed with any of the conditions set forth in the "What is limited under your Plan" Section.

Member

An Eligible Person who has enrolled for vision care coverage under the Group Contract.

Network

The facilities, providers, and suppliers who have contracted with EyeMed to provide vision care through us to you.

Network Provider

A Provider who contracted with EyeMed to provide Benefits through us to you.

Non Network Provider

A Provider who has not contracted with EyeMed to provide Benefits through us to you.

Open Enrollment Period

The yearly period when you can enroll in the Group Vision Plan.

Out Of Pocket Costs

Your expenses for vision care that aren't reimbursed by your Plan. Out of pocket costs include Copays and all costs for services and materials that aren't covered.

Participating Retailer

Retail chains that have contracted with EyeMed to provide Benefits through us to you.

Photochromic Lenses

Lenses that are clear indoors and darken when exposed to sunlight.

Photo Refractive Keratectomy (or **PRK**)

A type of refractive surgery to correct nearsightedness, farsightedness, and *astigmatism*.

Plan (or **Group Vision Plan**)

This vision care coverage plan offered to you by your Group through Surency Vision.

Plan Year

A 12-month period of Benefits coverage under the Group Vision Plan. This 12-month period may not be the same as the Calendar Year. To find out when your Plan begins, you can check your plan documents or ask your Group Administrator.

Plano Lenses

Lenses that provide no vision correction.

Plastic (Basic) Lenses

Lens material that is lighter in weight than glass lens.

Polarized Lenses

A lens add-on designed to reduce glare from surfaces, such as water, snow, and glass. This lens add-on is ideal for driving or outdoor activities, such as water and snow sports.

Polycarbonate Lenses

A lighter and thinner lens material that helps create a more impact-resistant lens.

Progressive Lenses

Lenses that are multi-focal with no lines.

Provider

A licensed optician, optometrist, or ophthalmologist who is able to provide vision care services or materials to you.

Qualifying Life Event

A change in your situation — like getting married or losing vision care coverage — that can make you eligible for a special enrollment period, allowing you to enroll in your Group's Plan outside the yearly Open Enrollment Period.

Schedule of Benefits (or **Schedule**)

An easy to read summary that lets you make comparisons of costs and coverage between Network and Non Network Providers. You can compare the Out Of Pocket Costs, Benefits, and other features that may be important to you.

Scratch-Resistant Coating

A lens add-on that helps reduce scratches on the lenses.

Severe Visual Problem

Visual problems are defined as severe for those who have a Best-Corrected Visual Acuity of 20/200 or less or have a very restricted field of vision.

Single Vision Lenses

Lenses for those who need vision correction for either far away or up close.

Spouse

Your spouse as determined under the laws of the state the marriage occurred.

Supplemental Testing

Diagnostic testing, other than comprehensive eye exams, that includes a review of the history of functional difficulties that involve things, such as reading, activities in the kitchen, glare problems, travel, work, watching television, school, and hobbies.

Surency

Surency Life & Health Insurance Company and its agents.

Surency Vision

Vision care plans underwritten by Surency Life & Health Insurance Company and administered by First America Administrators, Inc. using EyeMed Vision Care, LLC's provider network.

Tint

A lens add-on that reduces the light that enters the eyes.

Trifocal Lenses

Lenses for those who need correction for three fields of vision: far away, up close, and intermediate.

UV Coating

A lens add-on that protects eyes from ultraviolet (UV) light.

SURENCY LIFE AND HEALTH INSURANCE COMPANY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions concerning this notice, please contact:
Privacy Officer
Surency Life & Health Insurance Company
P.O. Box 789773
Wichita, KS 67278-9773
(316) 219-5749 or (888) 316-5986

Surency Life & Health Insurance Company, Inc. (the "Plan") is required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information and we are committed to protecting the privacy and confidentiality of your health and personal information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right To Inspect and Copy. You have the right to inspect and copy health information collected and maintained by the Plan. To inspect and copy your health information, you must complete a specific form providing information needed to process your request from the Privacy Officer at the address identified on this Notice. You may request that your health information be provided in an electronic form and we can work together to agree on an appropriate electronic format. You may be charged a fee to cover expenses associated with your request. We can refuse access under certain circumstances. If the Plan refuses access, you will be notified in writing and may be entitled to have a neutral person review the refusal.

Right To Amend Incorrect or Incomplete Information. You may request that Plan change your health information, although we are not required to do so. If your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing. You must also provide a reason for your request.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you, with certain exceptions specifically defined by law. To request this list or accounting of disclosures, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what

form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.
We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Alternative Methods of Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request an alternative method of communications, you must complete a specific form providing information we need to process your request. To obtain this form or to obtain more information concerning this process, please contact the Privacy Officer at the address identified on the first page of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the person identified on the first page of this Notice. You may obtain a copy of this notice at our website, http://www.surency.com.

Right to Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.

COMPLAINTS

If you believe your rights with respect to health information about you have been violated by the Plan, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person identified on the first page of this Notice. All complaints

must be submitted in writing. **You will not be penalized for filing a complaint**.

The effective date of this Notice is December 18, 2024. The Plan reserves the right to change the terms of this notice and to make the revised notice effective with respect to all protected health information regardless of when the information was created. If the notice is revised, the new notice will be provided to you, if you are still covered by the Plan, either through e-mail or U.S. postal service, within sixty days of such revision. Otherwise, we will provide you once every three years a reminder of the availability of this Notice and how to obtain the Notice.